CONNECTICUT COMMUNITY KID CARE INITIATIVE
CARE COORDINATION AND EMERGENCY MOBILE SERVICES
STAMFORD/NORWALK AREA

REQUEST FOR PROPOSAL

Notice to Bidders:

Attached is the Statewide RFP that was issued on August 5, 2001 for Care Coordination and Emergency Mobile Services. Additional clarifying information will be forwarded upon receipt of a Letter of Intent.

At this time, we are re-issuing the RFP for the Norwalk – Stamford Catchment area that includes the towns of Norwalk, Wilton, Weston, Westport, New Canaan, Darien, Greenwich and Stamford.

All of the Sections in the original RFP remain relevant for this issuing with the following exceptions:

#2, #3, #4, #6 on pages 6 and 7 are substituted with the following:

Letter of Intent is due by Friday, **January 4, 2002, by 5pm,** to the following:

Lois Mihalek
Community Services
Department of Children and Families
100 Fairfield Avenue
Bridgeport, CT 06604
Fax: (203) 384-5305

A Bidders Conference to be scheduled at a later date.

Applications are due not later then **February 8, 2002 by 5 pm**.

For questions pertaining to this RFP, please contact:

Hedy Gryszan
Program Director
DCF, Bridgeport Office
Phone: (203) 384-5379
Fax: (203) 384-5305

December 17, 2001

Connecticut Community KidCare Initiative

Care Coordination and Emergency Mobile Services

Request for Proposal

August 5, 2001

TABLE OF CONTENTS

I. INTRODUCTION

1. Background

The Department of Children and Families (DCF) and the Department of Social Services (DSS) are reorganizing and refinancing the public children's behavioral health service system in Connecticut. This initiative called Connecticut Community KidCare (CCKC) is designed to eliminate the major system gaps and barriers that have affected child behavioral health in recent years.

The impetus for this reform came in June 1999 when, in response to growing concern about serious bottlenecks and quality issues in children's mental health services, Connecticut's Legislature requested that DSS prepare a study of the financing and service delivery system for children's behavioral health. In February 2000, DSS, with assistance from DCF and other State agencies, submitted a report to the General Assembly entitled, "Delivering and Financing Children's Behavioral Health Services in Connecticut," prepared by the Child Health and Development Institute of Connecticut. This report identified significant problems in the way services are organized, financed, and delivered and pointed to five major needs of the service system:

A. Better mechanisms for coordination of care
B. Enhanced community-based resources and treatment alternatives
C. Integrated funding
D. Family involvement in policy as well as service planning for their own children
E. Redistribution of resources and refinancing of the service system

The report recommended that Connecticut move to a system of care approach for children's mental health services, building on the emerging network of 22 Community Collaboratives (formerly referred to as Local Systems of Care, LSOCs or SOCs) around the state. The system of care approach will actively involve families in service planning and creates the opportunity for flexibility in service planning so that children with behavioral health needs are better able to live in their homes and communities.

2. Overview of The Reform Initiative

Connecticut Community KidCare (CCKC) is designed to serve children enrolled in the State of Connecticut sponsored health insurance programs for families (HUSKY Part A and federally subsidized portions of HUSKY Part B) as well as DCF's Voluntary Services program. It will facilitate access to an expanded array of local, community-based, traditional and non-traditional services. Children with complex behavioral health service needs will have access to coordinated integrated care based on individualized service plans. These service plans will combine traditional clinical services (e.g., outpatient therapy, partial hospitalization, medication management) with non-traditional services (e.g., respite, mentoring, behavioral assistance, family-to-family support).

CCKC is based on a local service delivery model driven by the needs and preferences of the child and family. Reform efforts involve an expansion and redistribution of funds for children's behavioral health services, with greater emphasis on preventing children's problems from escalating by providing a wider array of culturally competent services delivered in the home or in the child's community. The reform will also support the

development and financing of an independent statewide family advocacy organization to provide family-to-family support and foster active family participation in treatment and system planning.

3. Care Coordination and Emergency Mobile Services

Key to this reform initiative is the design of a new statewide service that will provide a focused, therapeutic, mobile crisis response capacity coupled with care coordination. This service will be delivered across child welfare, behavioral health and juvenile justice systems as well as to children and youth not served through these mandates who are experiencing a psychiatric crisis. The goals of this model are as follows:

- Establish local points of access and assistance in each DCF region in response to children and youth experiencing a behavioral health crisis.
- Provide immediate, mobile, on-site crisis assessment and stabilization.
- Provide short-term, on-site therapeutic intervention.
- Provide intensive care coordination for children and youth with complex service needs.
- Participation in all collaboratives within each applicants' catchment area to ensure the balanced planning for and provision of both treatment needs and holistic child and family care.

NOTE WELL: This RFP supercedes a previously released DCF RFP (September 24, 2000) for Care Coordinator.

II. GENERAL INFORMATION AND OVERVIEW OF THE PROCUREMENT PROCESS

1. Purpose of the RFP

The Department of Children and Families will select entities who will be responsible to coordinate and deliver a system of mobile crisis and care coordination services for children and youth within an awarded catchment area. This system will provide an immediate mobile crisis response at the site of the crisis that is focused and therapeutic. Selected entities will have the capacity to provide a range of follow-up services including on-site clinical interventions and care coordination. The design of the system emphasisizes the following core elements:

A. In each catchment area, access to services through a local 800 phone number to register calls and provide the caller with a person to person connection. Immediate access to an Emergency Mobile Psychiatric Services (EMPS) clinician or redirection of the call to the police, medical service, child welfare Hotline or community service will be provided.
B. Statewide, a significant expansion in both mobile response capacity and the ability to provide a broad range of assessment, stabilization and short-term therapeutic interventions. Individual Crisis Plans (ICP) will be developed that may specify an average of six (6) weeks of clinical intervention at the site of the crisis delivered by experienced, licensed staff. This level of intervention will target children not currently receiving treatment services with a behavioral health provider. The focus of these efforts will be to prevent hospitalization or placement, to support families and

caregivers, offer specific behavioral assistance and assure the transition to a community-based support system that will remain in place when crisis stabilization has been achieved.

C. Expanded Care Coordination capacities within the same organizational structure to allow for timely assignment, consistent delivery of care coordination and further advancement of uniform training practice and data collection standards. Care Coordinators will be assigned up to a maximum of twelve (12) cases and will focus their efforts on working with children and youth with complex service needs and their families.

2. Letter of Intent

A non-binding Letter of Intent is required from each applicant. Letters of Intent will be distributed at the Bidder's Conference. Deadline for receipt of a Letter of Intent is August 24, 2001. Letter's of Intent will be mailed to the following address:

Dr. Karen Andersson
Director, Division of Mental Health
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

NOTE: ***Applicants who submit a Letter of Intent will receive copies of the questions and answers relative to this RFP.***

3. Mandatory Bidders Conference will be conducted at the following date, time and location:

Long Lane School Auditorium
Long Lane Road
Middletown, CT 06457
Thursday, August 16, 2001
10:00 a.m. – 12:00 p.m.

Failure to attend the mandatory Bidders Conference will constitute grounds for disqualification.

4. Bidders Feedback Process

All questions and comments with the Department regarding this RFP must be submitted in writing to Dr. Karen Andersson. The Department will accept written questions submitted by 3:00 p.m. on August 24, 2001. Written responses to all questions will be mailed to participants who have submitted a Letter of Intent.

5. Term of Contract

The Department intends to enter into a written State of Connecticut Core Contract with the successful applicant. The term of the initial contract will end on June 30, 2003. Care Coordination and Emergency Mobile Services contractual responsibilities are subject to change consistent with CCKC system design modifications. The Department reserves the option to extend the contract period. All contract extensions and modifications will be through contract amendment.

6. RFP Timetable

RFP ACTIVITY	DATE
RFP Released	August 5, 2001
Bidders Conference	August 16, 2001
Receipt of Letter of Intent	August 24, 2001
Receipt of Written Questions	August 24, 2001
DCF Responses to Questions	August 31, 2001
Proposals Due	September 24, 2001

Proposal review and notification timeframes will be based upon a state-wide rollout plan which will be discussed at the Bidders Conference.

7. Exclusionary Criteria

A provider would be excluded from this initiative if they are currently subject to DCF or other state agency licensing restriction, have had admissions closed by the Department or any state agency within the last six (6) months, or have had a contract amended, reduced or terminated within the last year due to programmatic concerns. A current investigation of Medicaid fraud or judgment involving Medicaid fraud within the past five (5) years would also exclude a provider from participation.

III. GENERAL PROPOSAL REQUIREMENTS

1. Responsive Proposals

In order to be evaluated and scored, applicants must submit a responsive proposal that, at minimum, meets the following requirements:

A. The original proposal and required copies must have been received by the response date identified in this RFP.
B. The proposal is submitted in the form described in Instructions for Preparing Responsive Proposals which will be disseminated and reviewed at the Mandatory Bidders Conference
C. The proposal includes a clear response to all requirements described in the RFP.
D. The respondent is not subject to any exclusionary criteria as set forth in this RFP.

2. Response Parameters

The Department will consider proposals submitted within the following parameters:

A. Single catchment area only.
B. More than one (1) catchment area but not the entire DCF region.
C. The entire DCF region.
D. A collaborative proposal for A, B, or C.

A respondent may submit an individual proposal in addition to collaborating in a consortium bid.

3. Points of Emphasis

NOTE WELL: In order to build on individual community strengths and effective service systems currently in place, the department will offer extra review points to applicants if the following conditions are fully met:

A. The applicant's response represents a collaborative bid, and includes a specific plan and written formal agreement to sub-contract with a local community-based entity currently providing or clearly demonstrating the ability to manage and provide culturally competent, responsive care coordination services in a specific catchment area.
B. The applicant's response represents a collaborative bid, and includes a specific plan and formal agreement to sub-contract with an entity currently providing a substantial, 24-hour crisis referral and response service.

4. Disposition of Proposals

The Department reserves the right to reject any and all proposals or portions thereof, received as a result of this request or to negotiate separately any service in any manner necessary to serve the best interests of the Department and/or the State. The Department reserves the right to contract for all or any portions of the scope of work contained within this RFP.

5 Proposal Review Process and Criteria

The Department will conduct a comprehensive, uniform, fair and impartial evaluation of proposals received in response to this RFP.

Each DCF Regional Administrator will establish a multidisciplinary Review Committee in order to assist in the selection of each Crisis and Coordination Service. Each committee will include a minimum of one (1) parent of a child or youth with SED. The Regional Office Review Committee will be responsible for the review and scoring of proposals. The Regional Administrator in conjunction with Central Office staff will formulate final recommendations for the Commissioner of the Department.

Proposal review criteria will be disseminated at the mandatory Bidders Conference.

6. Proposal Preparation Expenses

The State of Connecticut and the Department assume no liability for payment of expenses incurred by an applicant in preparing and submitting proposals in response to this RFP.

7. Freedom of Information

Due regard will be given to the protection of proprietary information contained in all proposals received, however, applicants should be aware that all materials associated with this procurement are subject to the terms of the Freedom of Information Act, the Privacy Act and all rules, regulations and interpretations resulting therefrom. It will not be sufficient for applicants to merely state generally that the proposal is proprietary in nature and not therefore subject to release to third parties. Those particular pages or sections that an applicant believes to be proprietary must be specifically identified as such. Convincing

explanation and rationale sufficient to justify each exception from release consistent with Section 1-198 of the Connecticut General Statutes must accompany the proposal. The rationale and explanation must be stated in terms of the proposed harm to the competitive position of the applicant that would result if the identified material were to be released and the reasons why the materials are legally exempt from release pursuant to the above-cited statute. In any case, the narrative portion of the proposal may not be exempt from release. Between the applicant and the Department, the final administrative authority to release or exempt any or all material so identified rests with the Department.

IV. BIDDER QUALIFICATIONS AND EXPERIENCE

The Department is interested in a clear understanding of each applicant's organizational qualifications and experience base relative to this RFP. To that end, please provide a detailed description of the following items. If this application represents a **collaborative bid**, **each member of the collaborative shall respond** to all the requirements in Section IV.

1. Location(s) and current service delivery catchment area(s).
2. Years in operation.
3. Agency description including:
    A. mission
    B. philosophy
    C. vision, and
    D. current range of services provided
4. Current Board members including ethnicity/national origin.
5. Experience in delivering behavioral health services to children and their families. Include a description sufficient to clarify your experience with children representing both the full age range (infants to young adults) as well as the full clinical risk spectrum.
6. Experience in working with systems representing the other mandates of the Department including prevention, substance abuse, juvenile justice and child welfare services.
7. Current membership(s) in local systems of care or community collaboratives. Include duration, frequency, and the nature of your participation. Include sufficient detail to illustrate your experience in fostering collaboration.
8. Current organizational structure. Submit an organizational chart that identifies key managers by name. Attach resumes of identified managers.
9. Medicaid provider status and history of providing service to low income, vulnerable populations.
10. Management information systems capacity and expertise.
11. A copy of all current certificates of accreditation or licensure.
12. Internal quality assurance structures and protocols including data collection, utilization review and evaluation of current programming.

In addition, the applicant must provide no less than ***four (4*) letters of support** for their candidacy in response to this RFP. At least *two (2)* are required from parents or family members who have utilized traditional behavioral health or non-traditional support services provided by the applicant; at least *two (2)* are required from community collaboratives operating within the catchment area identified in this RFP.

V. FAMILY PARTICIPATION

Families will play an instrumental role in ensuring that all aspects of Care Coordination and Emergency Mobile Services are accountable and responsive to the needs of children with behavioral health needs. DCF is supporting the development of a statewide family advocacy organization to assure that children with behavioral health needs and their families have input, access and ownership of the development and implementation of their service plans.

Each contractor must assure that families have opportunities as partners for involvement at multiple levels, from local advocacy to policy and planning. This baseline commitment to a consistent level of involvement will help make behavioral health services responsive to families and accountable to communities. This partnership will be evidenced by the families direct participation in crisis and service planning, the completion of client satisfaction surveys and inclusion on the performance feedback process.

Describe (context, role, frequency), the opportunities for family participation in your current program(s).

Describe your plan for providing assistance to families. Describe your mechanisms for fostering communication and coordination between families, service providers, community supports and DCF.

VI. CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES

As with family participation, a point of emphasis for the development of Care Coordination and Emergency Mobile Services is the enhanced ability to provide culturally and linguistically competent services. Staff must have the ability to provide services to all eligible participants, regardless of English language limitations. While the successful applicant must provide the most common languages, it may be necessary to make special arrangements for interpretive services to communicate with those speaking less frequently encountered languages.

Care Coordination and Emergency Mobile Services staff must demonstrate the following:

- Experience providing direct services to diverse populations
- Multi-lingual capabilities (relevant to community served)
- Shared cultural, linguistic or experimental backgrounds

Describe your current policy and process to recruit, hire and retain staff persons who represent the cultural and linguistic needs of the populations that you serve. Describe any internal quality improvement process you may utilize to evaluate the cultural competence of services that you provide.

Describe your plan to improve cultural and linguistic competency across the service network within your catchment area.

VII. EMERGENCY MOBILE PSYCHIATRIC SERVICES

Through this RFP, the Department is interested in developing a new statewide emergency mobile psychiatric service. The design of this service represents a significant expansion from the current DCF contracted model and will provide a hub in the delivery of community based behavioral health care. In addition to the services described in this RFP, the Department is committed to both expansion and the development of new community based services in the following areas: therapeutic respite, extended day treatment, in home therapeutic interventions and increased psychiatric services offered through the existing Child Guidance Clinic System.

The goal of this proposed model is to provide a consistent local point of access and assistance along with immediate, mobile on-site care from qualified mental health professionals. The proposed design must have the capacity to provide short-term clinical intervention as well as immediate access to a range of complimentary services including next day behavioral health appointments, medication assessment and management, containment and crisis stabilization beds and in-home therapeutic intervention.

The following table identifies funding parameters by DCF regional office for EMPS services. The regional distribution for SFY 02 was risk adjusted following consideration of HUSKY enrollees by town, DCF regional child welfare and juvenile justice placements in residential and group home care, and DCF regional total caseload distribution.

EMPS Funding Summary

DCF Region	SFY 01 Funding	Annualized 03 Funding
Southwest	$264,461.	$1,368,000.
South Central	$281,622.	$1,644,000.
Eastern	$230,857.	$1,116,000.
North Central	$312,870.	$1,932,000.
Northwest	$206,877.	$1,260,000.
Total	$1,296,687.	$7,320,000.

Target Population

EMPS providers will deliver a range of crisis response services and crisis stabilization services to children, youth, their families and caregivers including relative, adoptive and foster care providers. Children and youth in some congregate care settings such as emergency shelters and group homes may also require the assistance of an EMPS provider. These services will be available across child welfare, juvenile justice, prevention and behavioral health systems. The target population is defined as any child or youth in crisis. This includes any HUSKY A or B enrollee, DCF Voluntary Services program enrollee and any other child or youth.

Service Transition and Distribution

It is anticipated that there will be a minimum of five (5) and a maximum of twelve (12) Care Coordination and Emergency Mobile Services in operation following completion of this

procurement process. If necessary, currently funded EMPS programs will be carefully transitioned in order to assure continuity of clinical and ancillary services. DCF regional office staff will review proposals to assure appropriate distribution of service availability in the following catchment areas:

DCF Region	Potential Catchment Areas
Southwest	1. Greater Bridgeport and Stratford 2. Norwalk and Stamford
South Central	1. Greater New Haven 2. Middlesex County 3. Lower Naugatuck Valley
Eastern	1. New London County 2. Windham County
North Central	1. Greater Hartford 2. New Britain 3. Manchester
Northwest	1. Greater Waterbury 2. Danbury and Litchfield County

Key EMPS service delivery expectations include the following:

1. Access to Services

Each EMPS service must provide a centralized 800 phone number to serve as the point of entry and to provide person-to-person assistance and connection to crisis services. This centralized number will be available in each contracted catchment area and will be accessible 24 hours a day, 7 days a week, 365 days a year. In the event of a psychiatric emergency, a trained screener will facilitate direct contact with a licensed EMPS team member or other emergency service as necessary.

Detail your plan to develop and fully implement this intake screening and referral process in your proposed catchment area(s). This should include a description of the respondent's plan to inform and educate the community, especially family members about this service.

It is likely that some individuals calling the 800 number for assistance will currently be receiving services from a behavioral health provider in your catchment area. In this situation, how would you frame the functions, roles and clinical responsibilities of the EMPS separate from the behavioral health provider currently active with a child and/or family in crisis?

2. Operations and Direct Service Provision

Each EMPS program will be expected to provide a range of services that include:

- Phone assessment, triage and de-escalation
- General referral and or linkage to local behavioral health (mental health and substance abuse) and emergency services as necessary.
- Rapid (within 15 minutes) phone follow-up by licensed EMPS team member as necessary
- Availability of immediate psychiatric assessment and medication consultation.
- Mobile response at the site of the crisis within 30 minutes of the referral.

- Concurrent capacity to dispatch multiple EMPS teams throughout the catchment area.
- Scheduling adequate coverage for high and low utilization periods.
- Community outreach and education regarding the availability of EMPS

Detail your plan to develop and fully implement all aspects of this EMPS model. In addition:

A. Emergency Departments, Containment and Crisis Stabilization Options
A partnership with the judicious use of the hospital local Emergency Departments and the availability of containment and or crisis stabilization beds is critical to the successful treatment of children and youth experiencing a psychiatric crisis.

Detail your strategy (including letters of support or agreement) for facilitating critical linkage with your local Emergency Departments including the specific role differentiation between the Emergency Department and EMPS. Provide corresponding letters of support or agreement from Emergency Departments in your catchment area.

Provide a framework for how the Emergency Department and EMPS will work together. For example: What protocol will be followed when a parent brings a child (in psychiatric crisis) to the Emergency Room?

Clarify who in your proposed model has admitting privileges and how they will provide immediate assistance to your EMPS teams in facilitating a psychiatric admission.

Following consultation with providers in your catchment area, describe your collective recommendations for the development of adequate local capacity for containment and or crisis stabilization beds.

B. Medication Assessment and Short-Term Medication Management
Detail your plan (identify specific providers or agencies) to assure the immediate availability of medication assessment and the capacity for short-term medication management.

C. Home or Site-Based Care
Detail your therapeutic model and approach for providing short term, home or site-based clinical intervention and stabilization services. This EMPS design targets working with children and families for up to forty-five (45) days including up to six (6) to eight (8) home or site-based sessions when other clinical resources are not in place or when the child and family requires this additional, specialized service.

D. Linkage to Traditional and non-Traditional Support Services
Detail your plan to facilitate linkage and connection with traditional and non-traditional services and support systems including local community collaboratives in your catchment area.

3. Clinical Decision Protocols and Documentation
Through this RFP, the Department plans on initiating the use of standardized assessment tools and clinical decision protocols to assist in the development of an Individualized Crisis Plan (ICP) for each child or youth receiving services.

Each applicant must provide a narrative description of the clinical decision protocols they recommend be adopted by each EMPS. In addition, provide a sample of a Individualized Crisis Plan that contains a minimum of five (5) sections:

- Demographics
- Assessment
- Stabilization Interventions
- Disposition
- Community Linkage

4. Team Composition

The Department is interested in developing an EMPS model that uses highly trained, licensed clinical and medical staff. The EMPS design anticipates that most catchment areas will require the availability of two (2) mobile teams with the capacity to operate concurrently. In addition, a Comprehensive Care Manager position and a Service Effectiveness Coordinator position will be funded as a component of each EMPS service.

The inclusion of a Comprehensive Care Manager emphasizes the Department's commitment to expand the focus and treatment boundaries found in traditional EMPS models. The Comprehensive Care Manager will:

- Become the expert EMPS team resource regarding availability and access to non-clinical, non-traditional community supports including prevention and early intervention services.
- Assure attention to and planning for the comprehensive needs of each child and their families.
- Take the lead in facilitating the necessary linkages and transitions to non-traditional services and support systems.

The Department is equally committed to an on-going review of the quality and effectiveness of both Care Coordination and Emergency Mobile Services and the development of an inclusive process to inform practice and decision-making regarding these critical services. To that end a Service Effectiveness Coordinator will be funded as a component of each Care Coordination and Emergency Mobile Service contract with the following responsibilities:

- Measure and assess how the performance of services impacts outcomes for children and families
- Assure a significant focus on consumer satisfaction
- Provide quarterly feedback to families, collaboratives, providers and DCF regarding process and outcome targets.
- Assist in the development of a process where the inclusive review of performance data is done for the purposes of informing and improving practice.

Use of full-time, rather than a multiple, rotating part-time staffing model is seen as more effective in offering greater consistency and continuity of care. It is expected that each contractor will establish a policy and process to recruit and hire a diverse, culturally competent staff consistent with the catchment area it proposes to serve.

The final staffing composition for each EMPS will be negotiated based upon population within the catchment area, geography and adjusted for risk. The following offers a sample robust staffing model for a large catchment area:

EMPS Staffing Model (Sample)	
Personnel	**FTE**
Senior Executive	.25
Clinical Director	1.00
Admin. Assistant/Data Manager	.50
MSW/RN/APRN	5.50
Comprehensive Case Manager	1.00
Service Effectiveness Coordinator	1.00

VIII. CARE COORDINATION

The Department currently funds approximately 13.5 full-time Care Coordinators statewide through core contracts with fiduciary agencies. Historically, Care Coordinators have offered case management and coordination services to a range of children, youth and their families including those with complex service needs. Individuals in these positions are viewed as a prized and effective resource by parents, family advocates, and local community collaboratives. Under the direction of the Department, most Care Coordinators participated in the development of practice standards that led to the adoption of strength based assessment tools and a uniform client record.

Through this RFP, the Department seeks to capitalize on these efforts to embrace uniform practice standards. This RFP will provide the mechanism for hiring an additional thirty-eight (38) community-based Care Coordinators who will focus on working with children with complex service needs and their families. The approximate annual funding for all Care Coordinators will be $50,000 per FTE. The following table illustrates the anticipated distribution of additional Care coordinators:

DCF Region	Currently Funded Care Coordinators (FTE)	Additional Care Coordinators Through This RFP	Total Effective 7/1/02	Annualized 03 Funding
Southwest	3	7	10	$500,000.
South Central	5.5	7.5	13	$650,000.
Eastern	2	6	8	$400,000.
North Central	2	16	18	$900,000.
Northwest	1	7	8	$400,000.
TOTAL	**13.5**	**43.5**	**57**	**$2,850,000.**

All new Care Coordinators (43.5) will be hired, trained and supervised by the provider awarded the CCS contract(s). All existing Care Coordinators (13.5) will continue to provide services and receive supervision through the existing contract with a fiduciary agency. Effective July 1, 2002, all existing Care Coordinators (13.5) will transition directly or through sub-contract to a CCS umbrella agency. All Care Coordinators will continue to focus their efforts on working with children and youth with complex service needs and their families. No Care Coordinator will be expected to manage more than twelve (12) cases of any given time.

Care Coordination is a service involving direct client contact as well as indirect service provision. The contractor will assure that the care coordinators do not function as clinicians for the children or families they serve. Rather, care coordinators adhere to sound case practice standards and are informed by clinical knowledge. The contractor will provide region-wide oversight for the provision of the following care coordinator duties:

- Assist the family with developing and convening a Child Specific Team (CST) with the purpose of developing an Individualized Services Plan.
- Provision of linkage and coordination, including follow-up and advocacy for children/youth and families served.
- Referral intake and assessment of children/youth and families to be served using the approved Uniform Client Record and assessment tool(s).
- Development of a plan for each family served that guides the family to appropriate assistance and services in the event of a family mental health crisis.
- Maintenance of a uniform client record on all children and families receiving Care Coordination services. The contractor shall ensure that all such records are maintained in a secure manner in conformance with applicable state statutes.
- Weekly in-person and/or phone contact with families served and documentation of all contacts with these families.
- Work in conjunction with the DCF Social Worker to ensure seamless, collaborative care management for children/youth who are DCF involved.
- Provision of monthly reports concerning care updates; the number of open cases; number of waitlisted families; services accessed, needed by, or unavailable to children and their families; and/or basic aggregate demographic information of children and families served.
- Provision of client satisfaction survey to families and youth (children as appropriate) upon discharge from Care Coordination service.

When possible, applicants will be expected to pursue reimbursement for care coordination services rendered to HUSKY enrollees.

1. **Organizational Framework**
   If this application represents a collaborative proposal bid that includes a plan to subcontract for Care Coordination services, then the following organizational framework will be provided:

   A. Legal Name and address of each partner who will provide Care Coordination services.
   B. Proposed organizational framework of the partnership that identifies a single accountable agency who will enter into contract with DCF
   C. The specific catchment area(s) where Care Coordination services will be provided through a sub-contract arrangement.
   D. The proposed consortium administrative, supervisory and reporting structures
   E. Specific Memorandum of Agreement(s) regarding service partnerships and the provision of Care Coordination services.
   F. A clear accounting of and rationale for any additional administrative costs associated with a sub-contracting arrangement.

2. Oversight Responsibilities

Each applicant in response to this RFP must include a detailed response to the following questions. If your application includes a plan to sub-contract for all Care Coordination services, then the organization you plan to sub-contract with must respond to these questions. If the applicant proposes to provide as well as sub-contract for Care Coordination services, then both the applicant and the proposed sub-contractor must individually respond to these questions.

A. Describe your plan (or prior experience) as managers of care coordination services to embrace and include flexible creative, strength-based opportunities in working with children and families.
B. Describe your experiences in developing, organizing and managing informal helping networks.
C. Describe your experiences in advocating for individual families in your community. Be specific including your work with school, juvenile justice systems, adult court, assisting families apply for various services, and helping families navigate broader local or state systems.
D. How would you propose Care Coordinators be utilized to support and compliment the work of local Community Collaboratives; Family Advocates?
E. Detail you agencies specific experience in working with culturally and linguistically diverse clients. Provide specific information regarding the culturally relevant natural and formal resources and supports that your agency interacts with.
F. Provide a staffing matrix that identifies ethnicity/national origin, language fluency (oral and written), staff position and educational level.
G. Provide examples of your ability to provide materials in languages(s) of prevalent communities served.
H. Detail your plan to enhance and facilitate family participation. Address flexible hours, linguistic preparedness and transportation needs.

Describe your plan to provide routine individual and group clinical supervision and training to care coordinators.

IX. PROGRAM BUDGET

Each applicant as well as all proposed sub-contractors, will be required to submit a one (1) page summary that identifies direct and ancillary service staff positions, FTE and all overhead and administrative costs. The specific format will be included as part of the Instructions for Preparing Responsive Proposals and disseminated at the Bidder's Conference.

X. DCF ADMINISTRATIVE REQUIREMENTS

The following requirements will be included in all DCF contracts awarded through this RFP process.

1. Employment Screening

The contractor agrees to screen all employees including candidates for employment who will be providing direct services to children and families by obtaining verified criminal record information and children's protective services history prior to employment. The contractor

will develop written criteria, approved by DCF, for the hiring of individuals with a prior criminal record or protective service history. The contractor agrees to extend these same requirements to any subcontractor providing services through this RFP.

2. Pre-Service Training
The contractor agrees to provide all DCF required training to all employees prior to providing direct services to children and families served through the RFP.

3. Emergency Notification
The contractor agrees to develop and institute written protocols to assure the timely notification of police, emergency medical services, family members, DCF, Hot Line staff, and other community providers as appropriate in the event of an emergency, injury, or critical incident.

4. Physical Behavior Interventions (PBI)
Adhere to all statutory and regulatory requirements regarding the utilization of Physical Behavioral Interventions (restraint).

5. Investigations
The contractor agrees to cooperate fully with any protective service investigations involving children, youth or staff members. The contractor will develop and implement policy addressing administrative leave for staff identified in a protective services or criminal investigation.

6. Court Appearances
The contractor agrees to provide appropriate personnel to appear in court for the purpose of testifying to facts surrounding a client or provider's involvement in services covered under this RFP. When necessary, the contractor will provide a written summary in preparation for a juvenile court hearing.

XI. GENERAL LEGAL AND MANAGEMENT REQUIREMENTS

Applicants are required to provide a detailed description of the following requirements: **If this application represents a collaborative proposal bid, each member of the partnership shall respond to the following requirements.**

1. Incorporation
Identify if the applicant is incorporated including date of incorporation, evidence of incorporation including Articles of Incorporation, by-laws and other relevant documents.

2. For Profit or Not for Profit Status and Ownership
Identify the applicants For Profit or Not For Profit status including relevant documentation. Provide an organizational chart depicting ownership of the applicant.

3. Board of Directors

Provide the names, tenure and all pertinent affiliations of the individuals currently occupying positions on the applicant's Board of Directors. The Department expects that the Board or other advisory groups represent the diversity within the population and include both community and enrollee representation.

4. Subcontracting

Identify your intention to directly provide or subcontract for Emergency Mobile Psychiatric Services. If a subcontract arrangement is anticipated, the applicant is required to provide the following information:

A. Description of the systems and procedures the applicant will put in place to monitor a subcontractor's performance.
B. Contingency plan should the subcontractor be unable to temporarily (staff vacancy) or indefinitely meet the requirements of the contract.

5. Suspension or Termination of Provider Status

DCF reserves the right to require that a contractor suspend referrals to or terminate the use of any provider or subcontractor as a result of or during any investigation where the health, safety or welfare of children or families receiving services by that provider is shown to be adversely impacted.

XII. DATA MANAGEMENT AND REPORTING

The contractor must agree to adhere to reasonable requirements set forth by DCF regarding the development and implementation of performance goals and outcome measures. Goals and measurement data will be both program (service) specific and systemic and will be used for quality improvement and planning activities.

CONNECTICUT COMMUNITY KID CARE INITIATIVE
CARE COORDINATION AND EMERGENCY MOBILE SERVICES
STAMFORD/NORWALK AREA

RFP TIMELINE

Public Notice published, December 16, 2001

RFP released – December 17, 2001

Letter(s) of Intent due January 4, 2002

Bidders Conference (if more than one Letter of Intent) To be scheduled, if needed

Application Deadline – February 8, 2002

Packets out to Reviewers – February 11, 2002

Review Team Meeting – February 20, 2002

Recommendations to Regional Administrator – February 28, 2002

To Central Office for Commissioner's approval – March 5, 2002

Approval and Award Letter – March 8, 2002

Expected Start-up – April 1, 2002